neonatologist is not in-house, there must be one licensed physician (who has successfully completed the neonatal resuscitation program (NRP), or one neonatal nurse practitioner in-house for Level III NICU unit patients who require intensive care. A five year phase-in period will be allowed in order for the hospital to recruit adequate staff to meet these requirements. A Level III NICU unit shall have a neonatologist, or a licensed physician (who has successfully completed the neonatal resuscitation program (NRP), or a neonatal nurse practitioner in-house at all times.

b. Medical and surgical consultation must be readily available and pediatric subspecialists may be used in consultation with a transfer agreement with a Level III Regional NICU unit.

4. Nursing Staff

a. A nurse manager dedicated for the neonatal care area shall be available to all units. The nurse manager shall have specific training and experience in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager shall name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level III NICU unit will be 1:2-3.

5. Support Personnel. The following support personnel shall be available to the perinatal care service of Level II and Level III, and Level III Regional NICU units.

a. At least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy).

b. At least one occupational or physical therapist with neonatal expertise.

c. At least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates.

d. Qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel shall be readily available 24-hours a day).

e. Respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

Level III Regional Unit

1. Unit Mission. A Level III Regional NICU unit must be capable of the following:

a. must meet all requirements of all Level I, II and III NICU unit services at a superior level;

b. a Level III Regional NICU unit must have a transport team and provide for and coordinate a maternal and neonatal transport with Level I, Level II, and Level III NICU's throughout the state;

c. A Level III Regional unit shall be recognized as a medical center of excellence, and a center of research, educational and consultative support to the medical community.

2. Medical Staff

a. The medical director and/or department chief must be a board certified neonatologist.

b. In addition to the medical staff requirements for a Level III NICU unit, a Level III Regional NICU unit shall have the following subspecialties on staff and clinical services available to provide consultation and care in a timely manner:

Pediatric surgery	Pediatric cardiology
Pediatric neurology	Pediatric hematology
Genetics	Pediatric nephrology
Endocrinology	Pediatric gastroenterology
Pediatric infectious disease	Pediatric pulmonary medicine
Cardiovascular surgery	Neurosurgery
Orthopedic surgery	Pediatric urologic surgery
Pediatric ophthalmology	Pediatric ENT surgery
Pediatric nutritionist	Pediatric PT/OT
Neonatal Social Services	Bioethics committee

3. Nursing Staff

a. A nurse manager dedicated for the neonatal care area shall be available to all units. The nurse manager shall have specific training and experience in neonatal intensive care. The nurse manager shall participate in the development of written policies and procedures for the neonatal care areas, coordinate staff education and budget preparation with the medical director. The nurse manager shall name qualified substitutes to fulfill his or her duties during their absences. Nurse to patient ratios will vary with patient needs; however, the range for Level III Regional unit will be 1:1-2.

4. Support Personnel. The following support personnel shall be available to the perinatal care service of Level I, II, III, and III Regional NICU units:

a. at least one full-time medical social worker who has experience with the socioeconomic and psychosocial problems of high-risk mothers and fetuses, sick neonates, and their families (additional medical social workers may be required if the patient load is heavy);

b. at least one occupational or physical therapist with neonatal expertise;

c. at least one registered dietitian/nutritionist who has special training in perinatal nutrition and can plan diets that meet the special needs of high-risk mothers and neonates;

d. qualified personnel for support services such as laboratory studies, radiologic studies, and ultrasound examinations (these personnel shall be readily available 24-hours a day);

e. respiratory therapists or nurses with special training who can supervise the assisted ventilation of neonates with cardiopulmonary disease (optimally, one therapist is needed for each four neonates who are receiving assisted ventilation).

Pediatric Intensive Care Units

The new reimbursement methodology recognizes two categories of Pediatric Intensive Care Units (PICU). Although pediatric critical care is provided primarily at one level there

is a need for an additional level of care in geographic regions with small population base, to allow stabilization of critically ill children, to avoid long-distance transfers for disorders of less complexity or of low acuity. The criteria established for recognition as a PICU for Medicaid reimbursement purposes are as follows:

anization and Administrative Structure

There shall be a PICU Committee established as a standing committee of the hospital. It shall be composed of at least physicians, nurses, respiratory therapists and other disciplines as appropriate to the specific hospital unit. The committee shall participate in delineation of privileges for all personnel (both MD and NON-MD) within the unit. Policies and procedures shall be established by the medical director and the nurse manager in collaboration with the committee and approval of the medical staff and governing body. These written policies and procedures shall be maintained in the unit and shall include, but not be limited to, safety procedures, infection control, visitation, admission and discharge criteria, patient monitoring and record keeping, equipment preventive maintenance and repair.

Physical Design and Facilities

The Level I and II units shall be distinct, separate units within the hospital. There shall be clean and soiled utility rooms, isolation room capabilities, medication and nourishment storage areas, and a conference area available on the units.

Bedside Facilities

The head of each bed and/or crib shall be rapidly accessible for emergency airway management. Electrical power, oxygen, medical compressed air and vacuum outlets shall be available at each bed/crib. There shall be walls or curtains available at each bedside to provide for full visual privacy.

Medical Director

Level I units shall be (1) board-certified in pediatrics and board certified or in the process of board certification in Pediatric Critical Care Medicine [must be completed within five years]; (2) board certified in anesthesiology with practice limited to infants and children and with special qualifications as defined by the American Board of Anesthesiology) in critical care medicine; or (3) board certified in pediatric surgery with added qualifications in surgical critical care medicine (as defined by the American Board of Surgery). Level II medical director must meet the same criteria of Level I except the board certification in Pediatric Critical Medicine is not required. The medical director will name a qualified alternate to serve in his absence.

In existing units, consideration will be given to waiving this requirement for board certified pediatricians with a minimum of five years experience in pediatric care who are currently serving as medical directors of Level I and II units. The request for waiver must be made in writing to the Office of the Secretary.

Medical Staff

Level I and II units must have at least one physician of at least the postgraduate year 2 assigned to the PICU in house 24 hours per day. Other physicians including the attending physician or designee shall be available within 30 minutes. Level I units shall have on staff a pediatric anesthesiologist, surgeon, cardiothoracic surgeon, neurosurgeon, intensivist, cardiologist, neurologist, pulmonologist, hematologist/oncologist, endocrinologist, gastroenterologist, allergist or immunologist, as well as a radiologist, pathologist and a psychiatrist or psychologist. Level II units shall meet the above medical staff except the cardiothoracic surgeon and the pediatric subspecialties.

Nursing Staff

Level I and II shall have a unit manager dedicated to the unit who is a registered nurse with specific training and experience in pediatric critical care. The Level I manager shall be certified in critical-care nursing. The nurse manager shall name a qualified alternate to act in his/her absence. The staff to patient ratio shall vary with the acuity of the patients; however, the minimum shall be 1:3. There shall be an organized written orientation program as well as an ongoing in service/continued education program. (There shall be a three year phase-in period with regard to staffing requirements.)

Ancillary Support Personnel

For the Level I Units the respiratory therapy staff assigned to unit shall be in house 24 hours per day. Biomedical technicians shall be available within one hour, 24 hours a day. Unit clerk shall be readily available to the unit 24 hours a day. A pharmacist and radiologist must be in house 24 hours a day. Social worker, physical therapist and nutritionist are assigned to the unit as applicable.

For the Level II Units the respiratory therapist in house 24 hours a day. biomedical technician available within one hour 24 hours a day. Pharmacist and radiologist on call 24 hours a day. Unit clerks, social worker, physical therapist and nutritionist available as applicable.

Additional Hospital Facilities and Services

Level I units shall be located in Category 1 facility as defined by the American Academy of Pediatrics. The Emergency Department (ED) shall have a separate covered entrance. Two or more areas within the ED shall have the capacity and equipment to resuscitate any pediatric patient with any medical, surgical or traumatic illness facilities within Level I units. Hospitals with Level II units only need one such area. The emergency room shall be staffed 24 hours a day in facilities with either Level I or II units. There shall be a operating suite with one room available within 30 minutes and a second room within 45 minutes 24 hours a day. Hospitals with Level I units must have the capability of providing cardiopulmonary bypass, pediatric bronchoscopy and radiography. Clinical laboratories shall have micro-specimen capability, clotting studies with one hour turn around capability. There must also be the capability to perform complete blood cell count, differential count, platelet count, urinalysis, electrolytes, blood urea nitrogen, creatine, glucose calcium, prothrombin time, partial prothrombin time, and cerebrospinal fluid cell counts. Preparation of gram stains and bacteriologic cultures shall be available 24 hours per day. Blood gas values must be available within 15 minutes. Results of drug screening and levels of serum ammonia, serum and urine osmolarity, phosphorus and magnesium shall be available within three hours for Level I units. There must be

a blood bank able to provide all blood components 24 hours a day in both Level I and II. Cross matching shall allow for transfusions within one hour unless some unusual antibody is encountered. Hospitals with Level I units must have radiology services capable of portable radiography, fluoroscopy, computerized tomography scanning, ultrasonography, and nuclear scanning angiography. Diagnostic cardiac and neurologic studies shall be available to both Level I and II unit facilities. A catheterization laboratory or angiography suite must be present in facilities with Level I units. Level I units shall have the capability to provide hemodialysis 24 hours a day.

Equipment/Drugs

There shall be lifesaving therapeutic and monitoring equipment present in Level I and II units. There shall be a complete "code" or "crash" cart available on both Level I and II units. The cart contents should include, but not be limited to, approved medications, a defibrillator/cardioverter, automated blood pressure apparatus devices available on Level I and II units. All equipment shall be of proper size for infants and children. Oxygen tanks are needed for transport and backup for both Level I and II units. There will be additional equipment available to meet the needs of the patient population. Level I units shall have the capability of ventilator support. There must be bedside monitoring in all PICUs with the capability for continuously monitoring heart rate and rhythm, respiratory rate, temperature and one hemodynamic pressure. In level I, units must also have the ability to monitor systemic arterial, central venous, pulmonary arterial and intracranial pressures. The monitors must have alarms with both high and low settings and they must also have both audible and visible capability. There shall be a maintenance and calibration schedule maintained for all monitoring devices.

Pre-hospital Care

PICUs shall be integrated with the Regional EMS system as available. Rapid access to a Poison Control Center is essential. Each PICU shall have or be affiliated with a transport; system and team to assist other hospitals in arranging safe patient transport.

Miscellaneous Requirements

There shall be a quality assurance program in place which reviews quality of care and compares observed and predicted mortality rates for the severity of illness in the population of the PICU. Each Level I PICU shall offer pediatric critical care education for EMS providers, emergency department and transport personnel as well as for the general public. The staff nurses and respiratory therapists must also have Basic Life Support Certification.

Level I PICUs will possess sufficient patient volume, teaching expertise, and research capability to support a fellowship Program in Pediatric Critical Care. Programs providing sub-specialty training in critical care must possess approval by the residency review committee of the accreditation council on graduate medical education. Research is essential for improving our understanding of the pathophysiology affecting vital organ systems. Such knowledge is vital to improve patient care techniques and therapies and thereby decrease morbidity and mortality.

Burn Care Unit

Burn care units are to provide optimal care for patients with burn injuries (both adults and children) from the time of injury through rehabilitation. DHH is adopting the American Burn Association's guidelines which are specified below.

Organizational Structure Documentation of Policies and Procedures

The commitment of the institution's medical and administrative leadership should be documented in a burn center manual with policies specifying the commitment. Policies included should address the institutional relationships, administrative operation, staffing, and programs of the burn center.

The burn unit is a specialized nursing unit that is dedicated to burn care. The use of beds in the burn unit by other medical/surgical services should be governed by a protocol specifying priorities and assuring the availability of specialized burn beds for patients with acute burns when needed.

Relationship to Other Medical Staff

The availability and accessibility of consultation by physicians and surgeons in all specialties relevant to the care of the patient with burns should be documented. An on-call schedule should be established for the most important specialty areas.

Burn Service

An organized burn service should be formally established by the medical staff of the institution. The members of the burn service should be properly certified by the institution. The chief of the burn service should serve as the medical director of the burn center.

Qualifications of the Burn Center Director

The medical director of the burn center should be a licensed, board certified general or plastic surgeon on the active medical staff of the institution with at least 2 years experience in the management of patients in a burn center.

Responsibilities of the Burn Center Director

The medical director will be provided by the institution with the appropriate authority and responsibility to direct and coordinate all medical services to patients admitted to the burn center. The medical director will be responsible for regular communications with physicians and other authorities regarding referred patients, and for appropriate burn center management functions, including quality assurance, liaison with adjacent burn centers, internal and external education programs, and coordination with regional and state EMS programs. The burn center director will designate one or more appropriately certified physicians with at least six months experience in management of the patient with burns to be accessible for administrative and clinical decisions when the director is not available. The burn service director should participate actively in at least 50 cases a year.

Consistency of Protocol and Reporting

The care of the burn center patients accommodated in areas other than the specialized nursing unit should be guided by policies and protocols consistent with those of the burn unit. Similarly, annual statistical reports should encompass care provided both in the burn nursing unit and in other units accommodating burn center patients.